APPENDIX C
APPLICABLE STATUTES AND REGULATIONS

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Statutes

Regulations

STATUTES

211.461 Utilization Review. Definitions as used in KRS 211.461 to 211.466, unless the context otherwise requires:

(1) Cabinet" means the Cabinet for Human Resources;
(2) "Private review agent" means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any person providing or administering health benefits to citizens of this Commonwealth;
(3) "Registration" means an authorization issued by the cabinet to a private review agent to conduct utilization review;
(4) "Secretary" means the secretary of the Cabinet for Human Resources or his designee;
(5) "Utilization review"means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a patient or group of patients for purposes of determining the availability of payment; and
(6) "Utilization review plan" means a description of the procedures governing utilization review activities performed by a private review agent. (Enact. Acts 1990, ch. 451, § 1, effective July 13, 1990.)

342.020 Medical treatment at expense of employer; selection of physician and hospital; payment; managed health care system; artificial members and braces; waiver of privilege; disclosure of interest in referrals

(1) In addition to all other compensation provided in this chapter, the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical., and hospital treatment, including nursing, medical, and surgical supplies and appliances, as may reasonably be required at the time of the injury and thereafter during disability, or as may be required for the cure and treatment of an occupational disease. The employer's obligation to pay the benefits specified in this section shall continue for so long as the employee is disabled regardless of the duration of the employee's income benefits. In the absence of designation of a managed health care system by the employer, the employee may select medical providers to treat his injury or occupational disease. Even if the employer has designated a managed health care system, the injured employee may elect to continue treating with a physician who provided emergency medical care or treatment of the employee. The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The provider of medical services shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every forty-five (45) days thereafter, if appropriate, as long as medical services are rendered. Except as provided in subsection (4) of this section, in no event shall a medical fee exceed the limitations of an adopted medical fee schedule or other limitations contained in KRS 342.035, whichever is lower. The commissioner may promulgate administrative regulations establishing the form and content of a statement for services and procedures by which disputes relative to the necessity, effectiveness, frequency, and cost of services may be resolved.
(2) Notwithstanding any provision of the Kentucky Revised Statutes to the contrary, medical services and treatment provided under this chapter shall not be subject to copayments or deductibles.
(3) Employers may provide medical services through a managed health care system. The managed health care system shall file with the Department of Workers' Claims a plan for the rendition of health care services for work-related injuries and occupational diseases to be approved by the commissioner pursuant to administrative regulations promulgated by the commissioner.
(4) All managed health care systems rendering medical services under this chapter shall include the following features in plans for workers' compensation medical care:
    (a) Copayments or deductibles shall not be required for medical services rendered in connection with a work-related injury or occupational disease;
    (b) The employee shall be allowed choice of provider within the plan;
    (c) The managed health care system shall provide an informal procedure for the expeditious resolution of disputes concerning rendition of medical services;

(d) The employee shall be allowed to obtain a second opinion, at the employer's expense, from an outside physician if a managed health care system physician recommends surgery;

(e) The employee may obtain medical services from providers outside the managed health care system, at the employer's expense, when treatment is unavailable through the managed health care system;

(f) The managed health care system shall establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribe; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee; and

(g) Statements for services shall be audited regularly to assure that charges are not duplicated and do not exceed those authorized in the applicable fee schedules.

(h) A schedule of fees for all medical services to be provided under this chapter which shall not be subject to the limitations on medical fees contained in this chapter.

(I) Restrictions on provider selection imposed by a managed health care system authorized by this chapter shall not apply to emergency medical care.

(5) Except for emergency medical care, medical services rendered pursuant to this chapter shall be under the supervision of a single treating physician or physicians' group having the authority to make referrals, as reasonably necessary, to appropriate facilities and specialists. The employee may change his designated physician one (1) time and thereafter shall show reasonable cause in order to change physicians.

(6) When a compensable injury or occupational disease results in the amputation of an arm, leg, or foot, or the loss of hearing, or the enucleation of an eye or loss of teeth, the employer shall pay for, in addition to the other medical, surgical, and hospital treatment enumerated in subsection (1) and this subsection, a modern artificial member and, where required, proper braces as may reasonably be required at the time of the injury and thereafter during disability.

(7) Upon motion of the employer, with sufficient notice to the employee for a response to be filed, if it is shown to the satisfaction of the administrative law judge by affidavits or testimony that, because of the physician selected by the employee to treat the injury or disease, or because of the hospital selected by the employee in which treatment is being rendered, that the employee is not receiving proper medical treatment and the recovery is being substantially affected or delayed; or that the funds for medical expenses are being spent without reasonable benefit to the employee; or that because of the physician selected by the employee or because of the type of medical treatment being received by the employee that the employer will substantially be prejudiced in any compensation proceedings resulting from the employee's injury or disease; then the administrative law judge may allow the employer to select a physician to treat the employee and the hospital or hospitals in which the employee is treated for the injury or disease. No action shall be brought against any employer subject to this chapter by any person to recover damages for malpractice or improper treatment received by any employee from any physician, hospital, or attendant thereof.

(8) An employee who reports an injury alleged to be work-related or files an application for adjustment of a claim shall execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding any other provision in the Kentucky Revised Statutes, any physician, psychiatrist, chiropractor, podiatrist, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer, special fund, uninsured employers' fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation.

(9) When a provider of medical services or treatment, required by this chapter, makes referrals for medical services or treatment by this chapter, to a provider or entity in which the provider making the referral has an investment interest, the referring provider shall disclose that investment interest to the employee, the commissioner, and the employer's insurer or the party responsible for paying for the medical services or treatment, within thirty (30) days from the date the referral was made.

Effective: July 15, 1996

342.035 Medical fee schedule; review and updating; action for excess fees; effect of failure to submit to or follow surgical or medical treatment or advice; fee schedule for medical testimony; other medical matters.

(1) Periodically, the commissioner shall promulgate administrative regulations to adopt a schedule of fees for the purpose of ensuring that all fees, charges, and reimbursements under KRS 342.020 and this section shall be fair, current, and reasonable and shall be limited to such charges as are fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers. In determining what fees are reasonable, the commissioner may also consider the increased security of payment afforded by this chapter. On or before November 1, 1994, and on July 1 every two (2) years thereafter, the schedule of fees contained in administrative regulations promulgated pursuant to this section shall be reviewed and updated, if appropriate. Within ten (10) days of April 4, 1994, the commissioner shall execute a contract with an appropriately qualified consultant pursuant to which each of the following elements with the workers' compensation system are evaluated; the methods of health care delivery; quality assurance and utilization mechanisms; type, frequency, and intensity of services; risk management programs; and the schedule of fees contained in administrative regulation. The consultant shall present recommendations based on its review to the commissioner not later than sixty (60) days following execution of the contract. The commissioner shall consider these recommendations and, not later than thirty (30) days after their receipt, promulgate a regulation which shall be effective on an emergency basis, to effect a twenty-five percent (25%) reduction in the total medical costs within the program.

(2) No provider of medical services or treatment required by this chapter, its agent, servant, employee, assignee, employer, or independent contractor acting on behalf of any medical provider, shall knowingly collect, attempt to collect, coerce, or attempt to coerce, directly or indirectly, the payment of any charge, for services covered by a workers' compensation insurance plan for the treatment of a work-related injury or occupational disease, in excess of that provided by a schedule of fees, or cause the credit of any employee to be impaired by reason of the employee's failure or refusal to pay the excess charge. In addition to the penalty imposed in KRS 342.990 for violations of this subsection, any individual who sustains damages by any act in violation of the provisions of this subsection shall have a civil cause of action in Circuit Court to enjoin further violations and to recover the actual damages sustained by the individual, together with the costs of the lawsuit, including a reasonable attorney's fee.

(3) Where these requirements are furnished by a public hospital or other institution, payment thereof shall be made to the proper authorities conducting it. No compensation shall be payable for the death or disability of an employee if his death is caused, or if and insofar as his disability is aggravated, caused, or continued, by an unreasonable failure to submit to or follow any competent surgical treatment or medical aid or advice.

(4) The commissioner shall, by December 1, 1994, promulgate administrative regulations to adopt a schedule of fees for the purpose of regulating charges by medical providers and other health care professionals for testimony presented and medical reports furnished in the litigation of a claim by an injured employee against the employer. The workers' compensation medical fee schedule for physicians, 803 KAR 25:089, having an effective date of February 9, 1995, shall remain in effect until July 1, 1996, or until the effective date of any amendments promulgated by the commissioner, whichever occurs first, it being determined that this administrative regulation is within the statutory grant of authority, meets legislative intent, and is not in conflict with the provisions of this chapter. The medical fee schedule and amendments shall be fair, current, and reasonable and otherwise comply with this section.

(5) (a) To ensure compliance with subsections (1) and (4) of this section, the commissioner shall promulgate administrative regulations by December 31, 1994, which require each insurance carrier, group self-insurer, and self-insured employer to certify to the commissioner the program or plan it has adopted to ensure compliance.

(b) In addition, the commissioner shall periodically have an independent audit conducted by a qualified independent person, firm, company, or other entity hired by the commissioner, in accordance with the personal service contract provisions contained in KRS 45A.690 to 45A.725, to ensure that the requirements of subsection (1) of this section are being met. The independent person, firm, company, or other

entity selected by the commissioner to conduct the audit shall protect the confidentiality of any information it receives during the audit, shall divulge information received during the audit only to the commissioner, and shall use the information for no other purpose than the audit required by this paragraph.

(c) The commissioner shall promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer, or self-insured employer pursuant to this chapter.

(d) Periodically, or upon request, the commissioner shall report to the Interim Joint Committee on Labor and Industry of the Legislative Research Commission or to the corresponding standing committees of the General Assembly, as appropriate, the degree of compliance or lack of compliance with the provisions of this section and make recommendations thereon.

(e) The cost of implementing and carrying out the requirements of this subsection shall be paid from funds collected pursuant to KRS 342.122.

(6) The commissioner may promulgate administrative regulations incorporating managed care or other concepts intended to reduce costs or to speed the delivery or payment of medical services to employees receiving medical and related benefits under this chapter.

(7) For purposes of this chapter, any medical provider shall charge only its customary fee for photocopying requested documents. However, in no event shall a photocopying fee of a medical provider or photocopying service exceed fifty cents ($0.50) per page. In addition, there shall be no charge for reviewing any records of a medical provider, during regular business hours, by any party who is authorized to review the records and who requests a review pursuant to this chapter.

(8) (a) The commissioner shall develop or adopt practice parameters or guidelines for clinical practice for use by medical providers under this chapter. The commissioner may adopt any parameters for clinical practice as developed and updated by the federal Agency for Health Care Policy Research, or the commissioner may adopt other parameters for clinical practice which are developed by qualified bodies, as determined by the commissioner, with periodic updating based on data collected during the application of the parameters.

(b) Any provider of medical services under this chapter who has followed the practice parameters or guidelines developed or adopted pursuant to this subsection shall be presumed to have met the appropriate legal standard of care in medical malpractice cases regardless of any unanticipated complication that may thereafter develop or be discovered.

Effective: July 15, 1996

342.315 Medical evaluations by university medical schools; procedures; report; payment of costs; performance assessment of medical schools.

(1) The commissioner shall contract with the University of Kentucky and the University of Louisville medical schools to evaluate workers who have had injuries or become affective by occupational diseases covered by this chapter. Referral for evaluation may be made to one (1) of the medical schools whenever a medical question is at issue.

(2) The physicians and institutions performing evaluations pursuant to this section shall render reports encompassing their findings and opinions in the form prescribed by the commissioner. The clinical findings and opinions of the designated evaluator shall be afforded presumptive weight by arbitrators and administrative law judges and the burden to overcome such findings and opinions shall fall on the opponent of that evidence. When arbitrators or administrative law judges reject the clinical findings and opinions of the designated evaluator, they shall specifically state in the order the reasons for rejecting that evidence.

(3) The commissioner, an arbitrator, or an administrative law judge may, upon the application of any party or upon his own motion, direct appointment by the commissioner, pursuant to subsection (a) of this section, of a medical evaluator to make any necessary medical examination of the employee. Such medical evaluator shall file the commissioner within fifteen (15) days after such examination a written report. The medical evaluator appointed may charge a reasonable fee not exceeding fees established by the commissioner for those services.

(4) Within thirty (30) days of the receipt of a statement for the evaluation, the employer or carrier shall pay the cost of the examination. Upon notice from the

commissioner that an evaluation has been scheduled, the insurance carrier shall forward within seven (7) days to the employee the expenses of travel necessary to attend the evaluation at a rate equal to that paid to state employees for travel by private automobile while conducting state business.

(5) Upon claims in which it is finally determined that the injured worker was not the employee at the time of injury of an employer covered by this chapter, the special fund shall reimburse the carrier for any evaluation performed pursuant to this section for which the carrier has been erroneously compelled to make payment.

(6) Not less often than annual the designee of the secretary of the Cabinet for Human Resources shall assess the performance of the medical schools and render findings as to whether evaluations conducted under this section are being rendered in a timely manner, whether examinations are conducted in accordance with medically-recognized techniques, whether impairment ratings are in conformity with standards prescribed by the latest edition available of the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association, and whether coal workers' pneumoconiosis examinations are conducted in accordance with the standards prescribed in this chapter. (1966 1st ex s, c 1, §15, eff. 12-12-96.

342.990 Penalties; restitution

(1) The commissioner shall initiate enforcement of civil and criminal penalties imposed in this section.

(2) When the commissioner receives information that he deems sufficient to determine that a violation of this chapter has occurred, he shall seek civil penalties pursuant to subsections (3) to (7) of this section, or criminal penalties pursuant to subsections (8) and (9) of this section, or both.

(3) The commissioner shall initiate enforcement of a civil penalty by simultaneously citing the appropriate party for the offense and stating the civil penalty to be paid.

(4) If, within fifteen (15) working days from the receipt of the citation, a cited party fails to notify the commissioner that he intends to contest the citation, then the citation shall be deemed final.

(5) If a cited party notifies the commissioner that he intends to challenge a citation issued under this section, the commissioner shall cause the matter to be heard as soon as practicable by an administrative law judge and in accordance with the provisions of KRS Chapter 13B. The burden of proof shall be upon the attorney representing the commissioner to prove the offense stated in the citation by a preponderance of the evidence. The parties shall stipulate to uncontested facts and issues prior to the hearing before the administrative law judge. The administrative law judge shall issue a ruling within sixty (60) days following the hearing.

(6) A party may appeal the ruling of the administrative law judge to the Franklin Circuit Court in conformity with KRS 13B.140.

(7) The following civil penalties shall be applicable for violations of particular provisions of this chapter:

(a) Any employer, insurer, or payment obligor subject to this chapter who fails to make a report required by KRS 342.038 within fifteen (15) days from the date it was due, shall be fined not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each offense.

(b) Any employer, insurer, or payment obligor acting on behalf of an employer who fails to make timely payment of a statement for services under KRS 342.020(1) without having reasonable grounds to delay payment may be fined not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each offense.

(c) Any person who violates KRS 342.020(9), 342.035(2), KRS 342.040, 342.340, 342.400, 342.420, or 342.630 shall be fined not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each offense. With respect to employers who fail to maintain workers' compensation insurance coverage on their employees, each employee of the employer and each day of violation shall constitute a separate offense. With respect to KRS 342.040, any employer's insurance carrier or other party responsible for the payment of workers' compensation benefits shall be fined for failure to notify the commissioner of a failure to make payments when due if a report indicating the reason payment of income benefits did not commence within twenty-one (21) days of the date the employer was notified of an alleged work-related injury or disease is not filed with the commissioner within twenty-one (21) days

of the date the employer received notice, and if the employee has not returned to work within that period of time. The date of notice indicated in the report filed with the department pursuant to KRS 342.038(1), shall raise a rebuttable presumption of the date on which the employer received notice.

(d) Any person who violates any provisions of KRS 342.165(2), 342.335, 342.395, 342.460, 342.465, or 342.470 shall be fined not less than two hundred dollars ($200) nor more than two thousand dollars ($2,000) for each offense. With respect to KRS 342.395, each required notice of rejection form executed by an employee or potential employee of an employer shall constitute a separate offense.

(e) Any person who fails to comply with the data reporting provisions of administrative regulations promulgated by the commissioner pursuant to KRS 342.039, or with utilization review and medical bill audit administrative regulations promulgated pursuant to KRS 342.035(5), shall be fined not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each violation.

(f) Except as provided in paragraph (g) of this subsection, a person who violates any of the provisions of KRS 342.335(1) or (2) where the claim, compensation, benefit, or money referred to in KRS 342.335(1) or (2) is less than or equal to three hundred dollars ($300) shall be fined per occurrence not more that one thousand dollars ($1,000) per individual nor five thousand dollars ($5,000) per corporation, or twice the amount of gain received as a result of the violation, whichever is greater.

(g) Any person who violates any of the provisions of KRS 342.335(1) or (2) where the claim, compensation, benefit, or money referred to in KRS 342.335(1) or (2) exceeds three hundred dollars ($300) shall be fined per occurrence not more than five thousand dollars ($5,000) per individual nor ten thousand dollars ($10,000) per corporation, or twice the amount of gain received as a result of the violation, whichever is greater.

(h) Any person who violates the employee leasing provision of this chapter shall be fined not less than five hundred ($500) nor more than five thousand dollars ($5,000) for each violation.

(i) Any violation of the provisions of this chapter relating to self-insureds shall constitute grounds for decertification of such self-insured, a fine of not less than five hundred dollars ($500) nor more than five thousand dollars ($5,000) per occurrence, or both.

(j) Actions to collect the civil penalties imposed under this subsection shall be instituted in the Franklin District Court and the Franklin Circuit Court.

(8) The commissioner shall initiate enforcement of a criminal penalty by causing a complaint to be filed with the appropriate local prosecutor. If the prosecutor fails to act on the violation within twenty (20) days following the filing of the complaint, the commissioner shall certify the inaction by the local prosecutor to the Attorney General who shall initiate proceedings to prosecute the violation. The provisions of KRS 15.715 shall not apply to this section.

(9) The following criminal penalties shall be applicable for violations of particular provisions of this chapter:

(a) Any person who violates KRS 342.020(9), 342.035(2), 342.040, 342.400, 342.420, or 342.630, shall, for each offense, be fined not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000), or imprisoned for not less than thirty (30) days nor more than one hundred and eighty (180) days, or both.

(b) Any person who violates any of the provisions of KRS 342.165(2), 342.335, 342.460, 342.465, or 342.470 shall, for each offense, be fined not less than two hundred dollars ($200) nor more than two thousand dollars ($2,000), or imprisoned for not less than thirty (30) days nor more than one hundred and eighty (180) days, or both.

(c) Any corporation, partnership, sole proprietorship, or other form of business entity and any officer, general partner, agent, or representative of the foregoing who knowingly utilizes or participates in any employee leasing arrangement or mechanism as defined in KRS 342.615 for the purpose of depriving one (1) or more insurers of premium otherwise properly payable for the purpose of depriving the Commonwealth of any tax or assessment due and owing and based upon said premium shall upon conviction thereof be subject to a fine or not less than five hundred dollars ($500) nor more than five thousand dollars ($5,000), or imprisonment for not more than one hundred eighty (180) days, or both, for each offense.

(d) Notwithstanding any other provisions of this chapter to the contrary, when any employer,

insurance carrier, or individual self-insured fails to comply with is chapter for which a penalty is provided in subparagraphs (7), (8), and (9) above, such person, if the person is an owner in the case of a sole proprietorship, a partner in the case of a partnership, a principal in the case of a limited liability company, or a corporate officer in the case of a corporation, who knowingly authorized, ordered, or carried out the violation, failure, or refusal shall be personally and individually liable, both jointly and severally, for the penalties imposed in the above cited subparagraphs. Neither the dissolution nor withdrawal of the corporation, partnership, or other entity from the state, no the cessation of holding status as a proprietor, partner, principal, or officer shall discharge the foregoing liability of any person.

(10) Fines paid pursuant to subsections (7) and (9) of this section shall be paid into the special fund.

(11)In addition to the penalties provided in this section, the commissioner and any arbitrator, administrative law judge, or court of jurisdiction may order restitution of a benefit secured through conduct proscribed by this chapter. (1996 1st ex s, c 1, § 47, eff. 12-12-96)

REGULATIONS

803 KAR 25:012. Resolution of medical fee disputes.

RELATES TO: KRS Chapter 342
STATUTORY AUTHORITY: KRS Chapter 13A, 342.020, 342.035, 342.125, 342.260, 342.325, 342.735
NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 requires the Commissioner of the Department of Workers' Claims to promulgate administrative regulations necessary to carry on his work and the work of the administrative law judges under KRS Chapter 342. KRS 342.325 requires that questions arising under KRS 342 which are not settled by agreement of the parties shall be determined by an administrative law judge, and KRS 342.735 requires the commissioner to promulgate administrative regulations to expedite the payment of medical expense benefits. This administrative regulation regulates the resolution of medical fee disputes before the administrative law judges.

Section 1. Procedure (1) Disputes regarding payment, nonpayment, reasonableness, necessity, or work-relatedness of a medical expense, treatment, procedure, statement, or service which has been rendered or shall be rendered under KRS Chapter 342 will be resolved by an administrative law judge following the filing of a Form 112 (Medical Fee Dispute).

(2) (a) The Form 112 shall be accompanied by the following items: copies of all disputed bills, supporting affidavit(s) setting forth facts sufficient to show that the movant is entitled to the relief sought, necessary supporting expert testimony, and the final decision from a utilization review or medical bill audit with the supporting medical opinion.

(b) A single Form 112 may encompass statements, services, and treatment previously rendered as well as future statements, services, and treatment of the same nature or for the same condition, if specifically stated.

(3) An employee, provider of medical services, employer or employer's medical payment obligor may file a Form 112 to seek adjudication of a dispute involving medical expenses.

(4) If an application for adjustment of claim concerning the injury or disease which is the subject of the dispute has not been filed, copies of the Form 112 and attachments sufficient to serve the other parties, including the employee, the employer, the medical payment obligor, and the medical provider, shall be filed with the commissioner, who shall make service on the named parties. An opposing party may thereafter file a response, accompanied by affidavits setting forth facts sufficient to show that the movant is not entitled to the relief sought, within twenty (20) days after service by the commissioner. A response shall be served on the commissioner and the parties. This dispute shall be assigned to the Frankfort Administrative Law Judge motion docket, where it may be summarily decided upon the pleadings or assigned for further proof time and resolution by an administrative law judge.

(5) If an application for adjustment of claim is pending concerning the injury or disease which is the subject of the dispute, the movant shall file a Form 112 with the commissioner and shall also serve copies on the other parties of record. The movant shall further file a motion to join the medical provider as a party to the claim. This motion shall conform with the requirements of 803 KAR 25:010, Section 4.

(6) Following resolution of a workers' compensation claim by opinion or order of an administrative law judge, including an order approving settlement of a disputed

claim, a motion to reopen pursuant to 803 KAR 25:010, Section 4(6), shall be filed in addition to the Form 112. Unless utilization review has been initiated, the motion to reopen and Form 112 shall be filed within thirty (30) days following receipt of a complete statement for services pursuant to 803 KAR 25:096. The motion to reopen and Form 112 shall be served on the parties, upon the employee, even if represented by counsel, and upon the medical providers. If appropriate, the pleadings shall also be accompanied by a motion to join the medical provider as a party. This dispute shall be assigned to the Frankfort Administrative Law Judge motion docket, where it may be summarily decided upon the pleadings, or be assigned to an administrative law judge for further proof time and final resolution.

(7) If an appeal is pending before the Workers' Compensation Board concerning the injury or disease which is the subject of the dispute, the Form 112 shall be accompanied by a motion for a partial remand to the administrative law judge assigned to the claim, unless entitlement to medical services is dependent upon resolution of issues on appeal. If entitlement to medical services is dependent upon resolution of issues on appeal, the Form 112 shall be accompanied by a motion to the Workers' Compensation Board to hold the Form 112 in abeyance pending a final decision on the appeal.

(8) If the contested expense is subject to utilization review, a medical fee dispute shall not be filed prior to completion of the utilization review process. The thirty (30) day period for filing a medical fee dispute shall be tolled by commencement of the utilization review process. Notice of utilization review shall be provided to the affected parties pursuant to 803 KAR 25:096. The employer or its medical payment obligor shall have thirty (30) days following the final utilization review or medical bill audit decision to file a medical fee dispute.

(9) Repeated filing of identical Form 112's concerning the same subject matter shall not be necessary if an administrative law judge has ruled on both the past expenses and the necessity of future expenses. If an order from an administrative law judge encompassing future treatment or expenses become final, the medical provider shall not tender future statements for services encompassed by the order to the employer or its medical payment obligor.

(10) A party aggrieved by a decision of the administrative law judge in a medical fee dispute may appeal to the Workers' Compensation Board by following the procedures set forth in 803 KAR 25:010, Section 13.

Section 2. If the administrative law judge determines that proceedings have been brought, caused to be brought, prosecuted or defended without reasonable grounds, the entire cost of the proceedings, including attorneys fees, may be assessed upon the offending party pursuant to KRS 342.310. Sanctions shall be assessed, as appropriate, if an employer or a medical payment obligor challenges bills without reasonable medical or factual foundation, or if a medical provider, without reasonable foundation, submits bills for nonwork-related conditions to an employer or its medical payment obligor. Failing a medical fee dispute prior to exhaustion of required utilization review or medical bill audit procedures shall subject the movant to sanctions pursuant to KRS 342.310.

Section 3. Expedited Medical Fee Disputes. (1) If, prior to the filing of a formal application for adjustment of claim, a dispute arises requiring expedited determination of the reasonableness, appropriateness or employer's liability for proposed medical care, the lack of which could lead to serious physical or mental disability or death, an employee or employer may seek an expedited determination by filing a written request (on Form 120EX), together with:

(a) An affidavit of the employee or other witness that the injury or disease which is the subject of the dispute is compensable under KRS Chapter 342 in the format prescribed in Appendix A.

(b) An affidavit of a physician which explains why failure to obtain or undertake the proposed medical care within forty-five (45) days could lead to serious physical or mental disability or death of the employee. The physician's affidavit shall set forth the diagnosis of the patient, the clinical and diagnostic findings upon which the diagnosis is based, the proposed treatment, and the reason why immediate initiation of the proposed treatment is necessary. If feasible, an estimate of the cost of the proposed treatments shall be presented. The format for a physician's affidavit is set forth in Appendix B.

(c) Other affidavits or authenticated documents necessary to demonstrate that the movant is entitled to the relief sought.

(2) The Form 120EX and attachments shall be filed in triplicate with the commissioner who shall serve copies on the named parties. A respondent to a Form 120EX may file a response within ten (10) days of the date on which the Form 120EX is served by mail. Service shall be deemed complete the third day after mailing by the commissioner. A response shall be accompanied by affidavits setting forth facts sufficient to demonstrate that the movant is not entitled to the relief sought, and shall be served on the other parties by the respondent.

(3) The chief administrative law judge may refer the matter to an ombudsman to attempt to effectuate a resolution of the dispute.

(4) The administrative law judge to whom a request for expedited determination of medical issues is assigned shall issue a ruling within seven (7) days after expiration of the response time.

Section 4. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Form 112, "Medical Fee Dispute," (August 15, 1996 Edition), Department of Workers Claims; and

(b) Form 120EX, "Request for Expedited Determination of Medical Issue," (July 14, 1994 Edition), Department of Workers Claims.

(2) This material may be inspected, copied, or obtained at the Department of Workers Claims, Monday through Friday, 9 a.m. to 4 p.m., at the following locations:

(a) Perimeter Park West, Building C, 1270 Louisville Road, Frankfort, Kentucky 40601;

(b) 410 West Chestnut Street, Louisville, Kentucky 40202;

(c) 220B North 8th Street, Paducah, Kentucky 42001; or

(d) 101 Summit Drive, Pikeville, Kentucky 41501.

APPENDIX A
AFFIDAVIT OF EMPLOYEE

Affiant, (Name), first being duly sworn, states that the attached Request for Expedited Determination of Medical Issue (Form 120EX) concerns treatment for a condition compensable under the Kentucky Workers' Compensation Act. Affiant further states as follows:

1. Date and time of work-related injury or date on which occupational disease was discovered;

2. Brief description of how injury occurred or how occupational disease was acquired;

3. Date and identity of person to whom notice of injury or occupational disease was given;

4. Medical treatment at issue;

5. Attempts, if any, to obtain approval for contested treatment:

Signature:
STATE OF:
COUNTY OF:

Subscribed and sworn to before me by (name) this (day) day of (month), 19(year).

Notary Public:

My commission expires:

APPENDIX B
AFFIDAVIT OF PHYSICIAN
EXPEDITED MEDICAL DISPUTE

Affiant (Name), a physician whose area of specialization is (specialization), first being duly sworn, states that the attached Request for Expedited Determination of Medical Issue (Form 120EX) concerns a work-related injury or disease.

(1) The following medical care is required: (describe proposed medical care)

(2) the current working diagnosis is as follows:

(3) the proposed treatment is medically necessary because:

(4) The estimated cost of the proposed treatment is:

Affiant further states that failure of (Name of workers' compensation patient) to obtain or undertake this proposed medical care within the next forty-five (45) days could lead to serious physical or mental disability or death because:

Signature:
W.C. Medical Index No.:
Address:
STATE OF:
COUNTY OF:

Subscribed and sworn to before me by (name) this (day) day of (month), 19(year).

Notary Public:

My commission expires: (19 Ky.R. 1495; eff. 3-9-93; Am. 21 Ky.R. 569; eff. 10-10-94; 23 Ky.R. 1450; 2173; 2481; eff. 12-13-96.)

803 KAR 25:096. Selection of physicians, treatment plans and statements for medical services.

RELATES TO: KRS Chapter 342
STATUTORY AUTHORITY: KRS 342.020, 342.035, 342.260, 342.320, 342.735
NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 requires the Commissioner of the Department of Workers Claims to promulgate administrative regulations necessary to carry on the work

of the department under KRS Chapter 342. KRS 342.735 requires the commissioner to promulgate administrative regulations to expedite the payment of medical expense benefits. This administrative regulation regulates the selection of physicians and provides for treatment plans under KRS Chapter 342 in order to assure high quality medical care at a reasonable cost.

Section 1. Definitions. (1) "Designated physician" means the physician selected by the employee for treatment pursuant to KRS 342.020(5).

(2) "Emergency care" means:

(a) Those medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to a serious physical or mental disability or death; or

(b) Medical services which are immediately necessary to alleviate severe pain.

(3) "Long-term medical care" means:

(a) Medical treatment or medical rehabilitation that is reasonably projected to require a regimen of medical care for a period extending beyond ninety (90) days.

(b) Medical treatment that continues for a period of more than ninety (90) days.

(c) Medical treatment including the recommendation that the employee not engage in the performance of the employee's usual work for a period of more than sixty (60) days.

(4) "Physician" is defined in KRS 342.0011(32).

(5) "Statement for services" means:

(a) For nonpharamacuetical bills, a completed Form HCFA 1500, or for a hospital, a completed Form UB-92, with an attached copy of legible treatment notes, hospital admission and discharge summary, or other supporting documentation for the billed medical treatment, procedure, or hospitalization; and

(b) For pharmaceutical bills, a bill containing the identity of the prescribed medication, the number of units prescribed, the date of the prescription, and the name of the prescribing physician.

(6) "Treatment plan" means a written plan which may consist of copies of charts, consultation reports or other written documents maintained by the employee's designated physician discussing symptoms, clinical findings, results of diagnostic studies, diagnosis, prognosis, and the objectives, modalities, frequency, and duration of treatment. It shall include, as appropriate, details of the course of ongoing and recommended treatment and the projected results, and may be amended, supplemented or changed as conditions warrant.

Section 2. Employer's Obligation to Supply Kentucky Workers' Compensation Designation and Medical Release Card (Form 113). Within ten (10) days following receipt of notice of a work injury or occupational disease causing lost work time or necessitating medical treatment, the medical payment obligor shall mail a Form 113 to the employee, including a self-addressed, postage prepaid envelope for returning the Form 113. Failure by the medical payment obligor to timely mail the form shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the form.

Section 3. Employee Selection of Physician. (1) Except for emergency care, treatment for a work-related injury or occupational disease shall be rendered under the coordination of a single physician selected by the employee. The employee shall give notice to the medical payment obligor of the identity of the designated physician by tendering the completed Form 113, including a written acceptance by the designated physician, within ten (10) days after treatment is commenced by that physician.

(2) Within ten (10) days following receipt of a Form 113 designating a treating physician, the medical payment obligor shall tender a card to the employee, which shall be presented to a medical provider each time that medical services are sought in connection with the work-related injury or occupational disease.

(3) The card shall serve as notice to a medical provider of the identity of the designated physician, who shall have the sole authority to make referrals to treatment facilities or to specialists.

(a) The card shall bear the legend "First Designated Physician-Workers' Compensation" and shall further contain the following information:

1. Name and telephone number of the first designated physician;

2. Name, Social Security number, date of birth, and date of work injury or occupational disease and last exposure of the employee; and

3. Name and telephone number of the medical payment obligor.

(b) The reverse side of the first designated physician card shall contain:

1. A notice that treatment shall be performed by or on referral from the first designated physician; and

2. Shall further contain space for the identification and notification of a change of designated physician.

(4) Failure by the medical payment obligor to timely mail the "First Designated Physician" card shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the card.

Section 4. Change of Designated Physician. (1) Following initial selection of a designated physician, the employee may change designated physicians once without authorization of the employer or its medical payment obligor. Referral by a designated physician to a specialist shall not constitute a change of designated physician unless the latter physician is specifically selected by the employee as the second designated physician.

(2) Following a decision to change the designated physician, the employee shall complete the back of the first designated physician card and return the card with the name of the second designated physician to the medical payment obligor, which shall issue a second card within ten (10) days.

(3) The card shall bear the legend "Second Designated Physician-Workers' Compensation" and shall further contain the information required on the first designated physician card. The reverse side of the card shall contain a notice that:

(a) Treatment shall be performed by or on referral from the second designated physician; and

(b) A further change of designated physician shall require the written consent of the employer, its medical payment obligor or the administrative law judge.

(4) Failure by the medical payment obligor to timely mail the "Second Designated Physician" card shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the card.

(5) If an employee's two (2) choices of designated physician have been exhausted, he shall not, except as required by medical emergency, make an additional selection of a physician without the written consent of the employer, its medical payment obligor, or the administrative law judge. This consent shall not be unreasonably withheld.

(6) If the employer provides medical services through a managed health care system, it may establish alternate methods for provider selection within the managed health care plan.

Section 5. Treatment Plan. (1) A treatment plan shall be prepared if:

(a) Long-term medical care is required as a result of a work-related injury or occupational disease; or

(b) The employee has received treatment with passive modalities, including electronic stimulation, heat or cold packs, massage, ultrasound, diathermy, whirlpool, or similar procedures for a period exceeding sixty (60) days. The treatment plan shall detail the need for the passive treatment, the benefits, if any, derived from the treatment, the risks attendant with termination of the treatment, and the projected period of future treatment; or

(c) An elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program is recommended. The treatment plan shall set forth specific and measurable performance goals for the employee through the surgery, work hardening, or medical rehabilitation program.

(2) The designated physician shall provide a copy of the treatment plan to the medical payment obligor seven (7) days in advance of an elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program. In all other instances when a treatment plan is required, a copy of the treatment plan shall be provided within fifteen (15) days following a request by the medical payment obligor. An amendment, supplement, or change to a treatment plan shall be furnished within fifteen (15) days following a request.

(3) Preparation of a treatment plan shall be a necessary part of the care to be rendered and shall be an integral part of the fee authorized in the medical fee schedule for the underlying services. An additional fee shall not be charged for the preparation of a treatment plan or progress report, except for the reasonable cost of photocopying and mailing the records.

Section 6. Tender of Statement for Services. If the medical services provider fails to submit a statement for services as required by KRS 342.020(1) without reasonable grounds, the medical bills shall not be compensable.

Section 7. Written Denial of Statement for Services Prior to the Resolution of Claim. Prior to resolution of a workers' compensation claim by opinion or order of an administrative law judge, the medical payment obligor shall notify the medical provider and employee of its denial of a specific statement for services, or payment for future services from the same provider, in writing within forty-five (45) days following receipt of a completed statement for services. A copy of the denial shall be mailed to the employee, employer, and medical service provider. The denial shall include a statement of the reasons for denial and a brief synopsis of available utilization review or medical bill audit procedures with relevant telephone contact numbers. A denial shall be made only for good faith reasons. Upon receipt of a denial from a medical payment obligor, a medical provider may tender a statement for services to other potential payment sources or to the patient.

Section 8. Payment or Challenge to Statement for Services Following Resolution of Claim. (1) Following resolution of a claim by an opinion or order of an

administrative law judge, including an order approving settlement of a disputed claim, the medical payment obligor shall tender payment or file a medical fee dispute with an appropriate motion to reopen the claim, within thirty (30) days following receipt of a completed statement for services.

(2) The thirty (30) day period provided in KRS 342.020(1) shall be tolled during a period in which:

(a) the medical provider submitted an incomplete statement for services. The payment obligor shall promptly notify the medical provider of a deficient statement and shall request specific documentation. The medical payment obligor shall tender payment or file a medical fee dispute within thirty (30) days following receipt of the required documentation; or

(b) A medical provider fails to respond to a reasonable information request from the employer or its medical payment obligor pursuant to KRS 324.020(4); or

(c) The employee's designated physician fails to provide a treatment plan if required by this administrative regulation; or

(d) The utilization review required by 803 KAR 25:190 is pending. The thirty (30) day period for filing a medical fee dispute shall commence on the date of rendition of the final decision from the utilization review or medical bill audit. A medical fee dispute filed thereafter shall include a copy of the final utilization review or medical bill audit decision and the supporting medical opinions.

(3) An obligation for payment or challenge shall not arise if a statement for services clearly indicates that the services were not performed for a work-related condition.

Section 9. Payment Pursuant to Fee Schedules. If the statement for services contains charges in excess of those provided in the applicable fee schedule adopted by the commissioner in 803 KAR 25:089, 803 KAR 25:091, and 803 KAR 25:092, the medical payment obligor shall make payment in the scheduled amount and shall serve a written notice of denial setting forth the reason for refusal to pay a greater amount. Following receipt of a final medical bill audit reconsideration decision pursuant to 803 KAR 25:190, the medical provider may dispute the amount of payment within thirty (30) days by filing a medical fee dispute in accordance with 803 KAR 25:012.

Section 10. Patient Billing. (1) A medical provider may tender a statement for services to a patient once it has received a written denial from the medical payment obligor or has received an opinion by an administrative law judge finding that the services were unrelated to a work injury or occupational disease.

(2) The medical provider shall not bill a patient for services which have been found to be unreasonable or unnecessary by an administrative law judge, if the medical provider has been joined as a party to a workers' compensation claim or to a medical fee dispute and has had an opportunity to present any contrary evidence.

Section 11. Request for Payment for Services Provided or Expenses Incurred to Secure Medical Treatment. (1) If an individual who is not a physician or medical provider provides compensable services for the cure or relief of a work injury or occupational disease, including home nursing services, the individual shall submit a fully completed Form 114 to the employer or medical payment obligor within sixty (60) days of the date the service is initiated and every sixty (60) days thereafter, if appropriate, for so long as the services are rendered.

(2) Expenses incurred by an employee for access to compensable medical treatment for a work injury or occupational disease, including reasonable travel expenses, out-of-pocket payment for prescription medication, and similar items shall be submitted to the employer or its medical payment obligor within sixty (60) days of incurring of the expense. A request for payment shall be made on a Form 114.

(3) Failure to timely submit the Form 114, without reasonable grounds, may result in a finding that the expenses are not compensable.

Section 12. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Form 113, "Notice of Designated Physician," (August 15, 1996 Edition), Department of Workers claims; and

(b) Form 114, "Request for Payment for Services or Reimbursement for Compensable Expenses," (August 15, 1996 Edition), Department of Workers Claims.

(2) This material may be inspected, copied, or obtained at the Department of Workers Claims, Monday through Friday, 9 a.m. to 4 p.m., at the following locations:

(a) Perimeter Park West, Building C, 1270 Louisville Road, Frankfort, Kentucky 40601;

(b) 410 West Chestnut Street, Louisville, Kentucky 40202;

(c) 220B North 8th Street, Paducah, Kentucky 42001; or

(d) 101 Summit Drive, Pikeville, Kentucky 41501.

(19 Ky.R. 1498; Am. 1806; 2043; 2246; eff. 3-9-93; 23 Ky.R. 1455; 2177; 2485; eff. 12-13-96.)

803 KAR 25:190. Utilization review and medical bill audit.

RELATES TO: KRS Chapter 342

STATUTORY AUTHORITY: KRS 342.035(5), 342.260

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the Commissioner of the Department of Workers' Claims shall promulgate administrative regulations necessary to carry on the work of the Department of Workers' claims, and the commissioner may promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides that the Commissioner of the Department of Workers' Claims shall promulgate administrative regulations that require each insurance carrier, group self-insurer and individual self-insured employer to certify to the commissioner the program it has adopted to insure compliance with the medical fee schedule provisions of KRS 342.035(1) and (4). KRS 342.035(5) also requires the commissioner to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer or self-insured employer pursuant to KRS Chapter 342. This administrative regulation insures that insurance carriers, group self-insurers, and individual self-insured employers implement a utilization review and audit program.

Section 1. Definitions. (1) "Commissioner" is defined by KRS 342.0011(9).

(2) "Denial" means a determination by the utilization reviewer that the medical treatment or service under review is not medically necessary or appropriate and, therefore, payment is not recommended.

(3) "Medical bill audit" means the review of medical bills for services which have been provided to assure compliance with adopted fee schedules.

(4) "Preauthorization" means a review by the utilization review program of the medical necessity and appropriateness of medical services prior to the service being rendered.

(5) "Utilization review" means a review of the medical necessity and appropriateness of medical care and services for purposes of recommending payments for a compensable injury or disease. Medical services which are rendered or requested for incidents which are noncompensable under KRS Chapter 342 shall not be subject to utilization review.

(6) "Utilization review and medical bill audit plan" means the written plan submitted to the commissioner by each insurance carrier, individual self-insured employer, group self-insurer, or vendor describing the procedures governing utilization review and medical bills audit activities.

(7) "Vendor" means a person or entity which is not required to implement a utilization review or medical bill audit program, but which implements a utilization review and medical bill audit program for purposes of offering those services to insurance carriers, individual self-insured employers or group self-insurers.

Section 2. Utilization Review and Medial Bill Audit Program. (1) the utilization review program shall assure that:

(a) A utilization reviewer is appropriately qualified;

(b) Treatment rendered to an injured worker is medically necessary and appropriate; and

(c) Necessary medical services are not withheld or unreasonably delayed.

(2) The medical bill audit program shall assure that:

(a) A statement or payment for medical goods and services and charges for a deposition, report, or photocopy complies with KRS Chapter 342 and applicable administrative regulations;

(b) A medical bill auditor is appropriately qualified; and

(c) A statement for medical services is not disputed without reasonable grounds.

Section 3. Utilization Review and Medical Bill Audit Plan Approval. (1) An insurance carrier, individual self-insured employer, and group self-insurer shall fully implement and maintain a utilization review and medical bill audit program.

(2) Each insurance carrier, individual self-insured employer and group self-insurer shall provide to the commissioner a written plan describing the utilization review and medical bill audit program. The commissioner shall approve a utilization review and medical bill audit plan which complies with the requirements of this administrative regulation and KRS Chapter 342.

(3) A vendor shall submit to the commissioner for approval a written plan describing the utilization review and medical bill audit program. The utilization review and medical bill audit program described in the written plan shall comply with the requirements of this administrative regulation. Upon approval, the vendor shall receive written notice from the commissioner.

(4) Utilization review shall be performed by a private review agent certified by the Kentucky Cabinet for Health Services pursuant to KRS 211.461 to 211.466. A medical bill audit plan shall not require certification by the Kentucky Cabinet for Health Services.

(5) An insurance carrier, individual self-insured employer, and group self-insurer which contracts with an approved vendor for utilization review or medical bill audit services shall notify the commissioner of the contractual arrangement. The contractual arrangement may provide for separate utilization review and medical bill audit vendors.

(6) A plan shall be approved for a period of four (4) years, or until December 31, 2000, whichever is later. At least ninety (90) days prior to December 31, 2000, and every four (4) years thereafter, an insurance carrier, individual self-insured employer, group self-insurer, and approved vendor shall apply for renewal of the approval. During the term of an approved plan, the commissioner shall be notified as soon as practicable of a material change in the approved plan or a change in the selection of a vendor.

Section 4. Utilization Review and Medical Bill Audit Written Plan Requirements. The written utilization review and medical bill audit plan submitted to the commissioner shall include the following elements:

(1) A description of the process, policies and procedures whereby decisions shall be made.

(2) A description of the specific criteria utilized in the decision making process, including a description of the specific medical guidelines used as the resource to confirm the medical diagnosis and to provide consistent criteria and practice standards against which care quality and related costs are measured.

(3) A description of the criteria by which claims, medical services and medical bills shall be selected for review.

(4) A description of the qualifications of internal and consulting personnel who shall conduct utilization review and medical bill audit and the manner in which the personnel shall be involved in the review process.

(5) A description of the process to assure that treatment plans shall be obtained for review by qualified medical personnel if a treatment plan is required by 803 KAR 25:096.

(6) A description of the process to assure that a physician shall be designated by each injured employee as required under 803 KAR 25:096.

(7) A description of the process for rendering and promptly notifying the medical provider and employee of the initial utilization review decision.

(8) A description of the reconsideration process within the structure of the utilization review and medical bill audit program.

(9) An assurance that a database shall be maintained recording the instances of utilization review, medical bill audit, the name of the reviewer, the extent of the review, the conclusions of the reviewer, and the action, if any, taken as the result of the review. Data shall be maintained for a period of no less than two (2) years and shall be subject to audit by the commissioner, or his agent pursuant to KRS 342.035(5)(b).

(10) An assurance that a toll free line shall be provided for an employee or medical provider to contact the utilization reviewer. The reviewer or a representative of the reviewer shall be reasonably accessible to interested parties at least five (5) days per week, forty (40) hours per week during normal business hours.

(11) A description of the policies and procedures that shall be implemented to protect the confidentiality of patient information.

(12) An assurance that the acute low back pain practice parameter adopted by the commissioner pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for evaluating applicable low back claims. Additional medical guidelines which may be adopted by the commissioner pursuant to KRS 342.035(8)(a) shall be incorporated in a utilization review plan.

Section 5. Claim Selection Criteria. (1) Unless the claim is denied as noncompensable, a claim shall be subject to utilization review if:

(a) A medical provider requests preauthorization of a medical treatment or procedure; or

(b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received; or

(c) The total medical costs cumulatively exceed $3000; or

(d) The total lost work days cumulatively exceed thirty (30) days; or

(e) An administrative law judge orders a review.

(2) If applicable, utilization review shall begin no later than fifteen (15) days following the occurrence of a claims selection criteria. The initial utilization review decision shall be rendered within thirty (30) days of the initiation of the utilization review process.

(3) A medical provider may request an expedited utilization review determination for proposed medical treatment or services, the lack of which could reasonably be expected to lead to serious physical or mental disability or death. The expedited utilization review determination shall be provided within twenty-four (24) hours following a request for expedited review.

(4) Initiation of utilization review shall toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020. The thirty (30) day period shall commence on the date of the final utilization review decision.

(5) Each medical bill shall be audited within seven (7) days of receipt to assure:

(a) Compliance with applicable fee schedules;

(b) Accuracy; and

(c) That a physician has been designated in accordance with 803 KAR 25:096.

(6) A medical bill audit shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020.

Section 6. Utilization Review and Medical Bill Audit Personnel Qualifications. (1) Utilization review personnel shall have education, training, and experience necessary for evaluating the clinical issues and services under review. A licensed physician, registered nurse, licensed practical nurse, medical records technician or other personnel, who through training and experience is qualified to issue decisions on medical necessity or appropriateness, shall issue the initial utilization review approval.

(2) A licensed physician shall issue an initial utilization review denial. A licensed physician shall supervise utilization review personnel in making utilization review recommendations. Personnel shall hold the license required by the jurisdiction in which they are employed.

(3) Personnel conducting a medical bill audit, shall have the education, training or experience necessary for evaluating medical bills and statements.

Section 7. Written Notice of Denial. (1) Following initial review, a written notice of denial shall be issued to both the treating physician and the employee in a timely manner no more than thirty (30) days from the initiation of the utilization review process. The notice of denial shall be clearly entitled "UTILIZATION REVIEW-NOTICE OF DENIAL" and shall contain:

(a) A statement of the medical reasons for denial;

(b) The name, state of licensure and medical license number of the reviewer; and

(c) An explanation of utilization review reconsideration rights.

(2) Payment for medical services shall not be denied on the basis of lack of information absent documentation of a good faith effort to obtain the necessary information.

Section 8. Reconsideration. (1) A reconsideration process to appeal an initial decision shall be provided within the structure of utilization review. An aggrieved party may request reconsideration of the utilization review decision. Reconsideration of the initial utilization review decision shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer. A written decision shall be rendered within twenty-one(21) days of receipt of a request for reconsideration. The written decision shall be clearly entitled "UTILIZATION REVIEW - RECONSIDERATION DECISION." If the reconsideration decision is made by an appropriate specialist or subspecialist, the written decision shall further be entitled "FINAL UTILIZATION REVIEW DECISION." Those portions of the medical record that are relevant to the reconsideration, if authorized by the patient and in accordance with state or federal law, shall be considered and providers shall be given the opportunity to present additional information.

(2) If a utilization review denial is upheld upon reconsideration and a board eligible or certified physician in the appropriate specialty or subspecialty area has not previously reviewed the matter, an aggrieved party may request further review by a board eligible or certified physician in the appropriate specialty or subspecialty. A written decision shall be rendered within ten (10) days of the request for specialty reconsideration. The specialty decision shall be clearly entitled 'FINAL UTILIZATION REVIEW DECISION".

(3) A reconsideration process to appeal an initial decision shall be provided with the structure of medical bill audit. An aggrieved party may request reconsideration of the medical bill audit decision. Reconsideration shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer. A written decision shall be rendered within seven (7) days of receipt of a request for reconsideration. The written decision shall be clearly entitled 'MEDICAL BILL AUDIT - RECONSIDERATION DECISION.' A request for reconsideration of the medical bill audit decision shall

not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020. (22 Ky.R. 303; Am. 740; eff. 9-19-95; 23 Ky.R. 1459; 2181; 2489; eff. 12-13-96.)